

§ 156.80

(ii) Documentation demonstrating that the payments for contraceptive services were made in compliance with 26 CFR 54.9815-2713A(b)(2) or 29 CFR 2590.715-2713A(b)(2).

(iii) Documentation supporting the total dollar amount of the payments for contraceptive services submitted by the third party administrator, as described in paragraph (d)(2)(iii)(D) of this section.

[77 FR 18468, Mar. 27, 2012, as amended at 78 FR 15535, Mar. 11, 2013; 78 FR 39897, July 2, 2013]

§ 156.80 Single risk pool.

(a) *Individual market.* A health insurance issuer must consider the claims experience of all enrollees in all health plans (other than grandfathered health plans) subject to section 2701 of the Public Health Service Act and offered by such issuer in the individual market in a state, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(b) *Small group market.* A health insurance issuer must consider the claims experience of all enrollees in all health plans (other than grandfathered health plans) subject to section 2701 of the Public Health Service Act and offered by such issuer in the small group market in a state, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(c) *Merger of the individual and small group markets.* A state may require the individual and small group insurance markets within a state to be merged into a single risk pool if the state determines appropriate. A state that requires such merger must submit to CMS information on its election in accordance with the procedures described in § 147.103 of this subchapter.

(d) *Index rate—(1) In general.* A health insurance issuer must establish an index rate that is effective January 1 of each calendar year for a state market described in paragraphs (a) through (c) of this section based on the total combined claims costs for providing essential health benefits within the single risk pool of that state market. The index rate must be adjusted on a market-wide basis for the state based on

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the total expected market-wide payments and charges under the risk adjustment and reinsurance programs, and Exchange user fees (expected to be remitted under § 156.50(b) or § 156.50(c) and (d) of this subchapter as applicable plus the dollar amount under § 156.50(d)(3)(i) and (ii) of this subchapter expected to be credited against user fees payable for that state market). The premium rate for all of the health insurance issuer's plans in the relevant state market must use the applicable market-wide adjusted index rate, subject only to the plan-level adjustments permitted in paragraph (d)(2) of this section.

(2) *Permitted plan-level adjustments to the index rate.* For plan years or policy years beginning on or after January 1, 2014, a health insurance issuer may vary premium rates for a particular plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors:

(i) The actuarial value and cost-sharing design of the plan.

(ii) The plan's provider network, delivery system characteristics, and utilization management practices.

(iii) The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

(iv) Administrative costs, excluding Exchange user fees.

(v) With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

(3) *Frequency of index rate and plan-level adjustments.* (i) A health insurance issuer may not establish an index rate and make the market-wide adjustments pursuant to paragraph (d)(1) of this section, or make the plan-level adjustments pursuant to paragraph (d)(2) of this section, more or less frequently than annually, except as provided in paragraph (d)(3)(ii) of this section.

(ii) Beginning the quarter after HHS issues notification that the FF-SHOP

can process quarterly rate updates, a health insurance issuer in the small group market (not including a merged market) may establish index rates and make the market-wide adjustments pursuant to paragraph (d)(1) of this section, and make the plan-level adjustments pursuant to paragraph (d)(2) of this section, no more frequently than quarterly, provided that any changes to rates must have effective dates of January 1, April 1, July 1, or October 1.

(e) *Grandfathered health plans in the individual and small group market.* A state law requiring grandfathered health plans described in §147.140 of this subchapter to be included in a single risk pool described in paragraphs (a) through (c) of this section does not apply.

(f) *Applicability date.* The provisions of this section apply for plan years (as that term is defined in §144.103 of this subchapter) in the group market, and for policy years (as that term is defined in §144.103 of this subchapter) in the individual market, beginning on or after January 1, 2014.

[78 FR 13441, Feb. 27, 2013, as amended at 78 FR 39898, July 2, 2013; 78 FR 65096, Oct. 30, 2013]

Subpart B—Essential Health Benefits Package

SOURCE: 78 FR 12866, Feb. 25, 2013, unless otherwise noted.

§ 156.100 State selection of benchmark.

Each State may identify a single EHB-benchmark plan according to the selection criteria described below:

(a) *State selection of base-benchmark plan.* The options from which a base-benchmark plan may be selected by the State are the following:

(1) *Small group market health plan.* The largest health plan by enrollment in any of the three largest small group insurance products by enrollment, as defined in §159.110 of this subpart, in the State's small group market as defined in §155.20 of this subchapter.

(2) *State employee health benefit plan.* Any of the largest three employee health benefit plan options by enrollment offered and generally available to State employees in the State involved.

(3) *FEHBP plan.* Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by aggregate enrollment that is offered to all health-benefits-eligible federal employees under 5 USC 8903.

(4) *HMO.* The coverage plan with the largest insured commercial non-Medicaid enrollment offered by a health maintenance organization operating in the State.

(b) *EHB-benchmark selection standards.* In order to become an EHB-benchmark plan as defined in §156.20 of this subchapter, a state-selected base-benchmark plan must meet the requirements for coverage of benefits and limits described in §156.110 of this subpart; and

(c) *Default base-benchmark plan.* If a State does not make a selection using the process described in this section, the default base-benchmark plan will be the largest plan by enrollment in the largest product by enrollment in the State's small group market.

[78 FR 12866, Feb. 25, 2013, as amended at 80 FR 10871, Feb. 27, 2015]

§ 156.105 Determination of EHB for multi-state plans.

A multi-state plan must meet benchmark standards set by the U.S. Office of Personnel Management.

§ 156.110 EHB-benchmark plan standards.

An EHB-benchmark plan must meet the following standards:

(a) *EHB coverage.* Provide coverage of at least the following categories of benefits:

- (1) Ambulatory patient services.
- (2) Emergency services.
- (3) Hospitalization.
- (4) Maternity and newborn care.
- (5) Mental health and substance use disorder services, including behavioral health treatment.
- (6) Prescription drugs.
- (7) Rehabilitative and habilitative services and devices.
- (8) Laboratory services.
- (9) Preventive and wellness services and chronic disease management.
- (10) Pediatric services, including oral and vision care.

(b) *Coverage in each benefit category.* A base-benchmark plan not providing any